State of California
Division of Workers' Compensation
Disability Evaluation Unit

DEU Use Only

REQUEST FOR SUMMARY RATING DETERMINATION of Qualified Medical Evaluator's Report

INSTRUCTIONS TO THE CLAIMS ADMINISTRATOR:

1. Use this form if employee is unrepresented and has not filed an application for adjudication.
2. Complete this form and forward it along with a complete copy of all medical reports and medical records concerning this case to the physician scheduled to evaluate the existence and extent of permanent impairment or disability.
3. Send the EMPLOYEE'S DISABILITY QUESTIONNAIRE, DEU FORM 100 to the employee in time for the medical evaluation.
4. **This form must be served on the employee prior to the evaluation. Be sure to complete the proof of service.**

INSTRUCTIONS TO THE PHYSICIAN:

1. If the employee is unrepresented, review and comment upon the Employee's Disability Questionnaire, (DEU Form 100), in your report. (If the employee does not have a completed Form 100 at the time of the appointment, please provide the form to the employee.)
2. Submit your completed medical evaluation and, if the employee is unrepresented, the DEU Form 100, to the Disability Evaluation Unit district office listed below.**PLEASE USE THIS FORM AS A COVER SHEET FOR SUBMISSION TO THE DISABILITY EVALUATION UNIT.**
3. Serve a copy of your report and the Form 100 upon the claims administrator and the employee.

Date of first medical report indicating the existence of permanent impairment or disability: _____
MM/DD/YYYY

Last date for which temporary disability indemnity was paid: _____
MM/DD/YYYY

Submit To: Disability Evaluation Unit

_____
Address/PO Box (Please leave blank spaces between numbers, names or words)

_____ _____ _____
City State Zip Code

_____
Physician

Exam Date _____
MM/DD/YYYY

Claims Administrator

Company Name

Address 1/PO Box (Please leave blank spaces between numbers, names or words)

Address 2/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Claim No. 1

Claim No. 2

Claim No. 3

Claim No. 4

Claim No. 5

Phone No.

Adjustor

Employer

Employee

First Name MI

Last Name

Address 1/PO Box (Please leave blank spaces between numbers, names or words)

Address 2/PO Box (Please leave blank spaces between numbers, names or words)

International Address (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

Date of Injury _____ (MM/DD/YYYY)

Date of Birth _____ (MM/DD/YYYY)

SSN (Numbers Only) _____

WCAB Case No. (if any) _____

OCCUPATION_____
(Please attach job description or job analysis, if available)

WEEKLY GROSS EARNINGS_____

(Attach a wage statement/DLSR 5020 if earnings are less than maximum. Include the value of additional advantages provided such as meals, lodging, etc. If earnings are irregular or for less than 30 hours per week, include a detailed description of all earnings of the employee from all sources, including other employers, for one year prior to the date of injury. Benefits will be calculated at MAXIMUM RATE unless a complete and detailed statement of earnings is attached.)

PROOF OF SERVICE BY MAIL

On _____, I served a copy of this Request for Summary Rating Determination on

Name of Employee _____

Address _____

City _____ State _____ Zip _____

by placing a true copy enclosed in a sealed envelope with postage fully prepaid, and deposited in the U.S. Mail. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____

Signature